Community Radio Listening Groups:

Expanding the reach of MAHEFA's behavior change empowerment strategy

Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment, Community Radio Listening Groups, Community Score Card Approach, Chlorhexidine 7.1%/ Misoprostol, Champion Communes Approach, Community Health Volunteer Mobility, Emergency Transport Systems, Malaria, Community Health Volunteer Motivation, Family Planning & Youth, WASH, eBox, Community Health Financing Scheme, Information Systems for Community Health and NGO Capacity Building.*

Background

Behavior change empowerment (BCE) strategies, which are often employed via television, radio, community events, interpersonal communication, telephone, SMS, and the internet, among others, have real potential to reach large numbers of people with health messages and bring about positive behavior change. BCE builds on locally available data to shift health norms and behaviors at the population level. It can also improve health provider and client interactions, increase demand for health services and products, strengthen a community's response to a health issue, and influence health policy.

MAHEFA Context

In Madagascar, radio programs play an important role in promoting development themes thanks to robust radio coverage and high listening rates: 57 percent of rural households own a radio, and 50 percent of women and 55 percent of men in rural areas listen to the radio at least once a week[1]. Radio formats that generate dialogue and exchange experiences, such as community reporting, storytelling and radio theater, are effective means of transmitting messages. To optimize collective listening in public places, MAHEFA used the Radio Listening Group (RLG) approach in their program regions.

The MAHEFA Approach

In order to develop its BCE strategy, MAHEFA conducted formative research that revealed information on key barriers to health behavior change in intervention areas such as maternal, newborn, and child health, family planning and reproductive health, sexually transmitted infections, water, sanitation, and hygiene, nutrition, and malaria treatment. RLGs were identified as an important component of the MAHEFA BCE strategy to assist individuals and communities overcome barriers to healthy behaviors and influence their commitment to take charge of their own health. Through the RLG approach, MAHEFA developed radio programs promoting good health practices that were broadcast across all program regions. Community members attended RLGs to listen to the broadcasts, discuss the health messages and share their knowledge and experience using local solutions to address targeted health issues and change community norms.

RLGs require the involvement of various entities such as local radio stations, community health volunteers (CHVs), and local health committees (COSANs) who ensure that messages correspond with their activities, are produced in the local dialect, and are easy to remember. Through RLGs, community members discussed health issues and increased their knowledge of how to reduce health risk and become change agents. The dynamism and team spirit that often occurred during the RLGs facilitated the introduction of new practices for health promotion and methods to seek appropriate care. Though behaviors can be hard to change on an individual level, those who participated in collective actions, such as RLGs, found it easier to achieve change. The

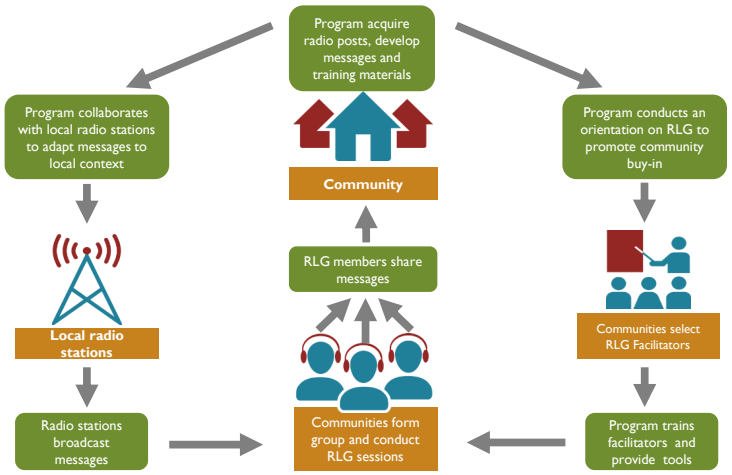
1. *Institut National de la Statistique (INSTAT) et ICF Macro. 2010. Enquête Démographique et de Santé de Madagascar 2008-2009. Antananarivo, Madagascar : INSTAT et ICF Macro.*

groups created environments where health and social norm shifts had ripple effects as they became visible and were able to generate wider social change. MAHEFA's experience confirms that using RLGs as a component of community-based BCE interventions complements health service delivery activities and helps community members achieve a healthier life for themselves and their families.

Key Activities

Figure 1 represents MAHEFA's implementation steps for RLGs:

Figure 1. MAHEFA's Radio Listening Group (RLG) Model



1. Acquired donated radios for use in the listening group activities. MAHEFA received 839 solar manual windup radios from the Executive Secretariat of the National Committee to Fight against HIV/AIDS with the agreement that key health messages disseminated through MAHEFA's radio program include messages on reproductive health including prevention of sexually transmitted illnesses (STI).

2. Developed key health messages for dissemination via various short- and long-format broadcasts. Key health messages were developed from formative research on current health practices in target regions and were transformed into local dramas and short radio clips. MAHEFA collaborated with 26 local radio stations to adapt health messages to local contexts and ensure timely dissemination of messages, collect data and review listening rates, and discuss other feedback the radio stations received about the health broadcasts.

3. Conducted rapid community-level orientation meetings to present the RLG concept and get buy-in. MAHEFA's field team presented the RLG concept to local leaders such as chiefs of *fokontany* (a collection of villages) and other community members. Community leaders who expressed interest in the concept then identified facilitators for each RLG. During community-level orientation meetings, community leaders also learned about their roles which included monitoring RLG activities.

4. Developed curriculum and conducted training for RLG facilitators. 763 RLG facilitators were trained at least twice (pre-service and in-service) on health messages and facilitation skills. They were given a solar manual windup radio and received quarterly follow-up visits through MAHEFA to collect attendance data, discuss challenges and identify progress. Approximately half of the RLG facilitators in the MAHEFA regions were also CHVs. In these cases, there was an added advantage, given that CHVs are the basis of the community health structure, are already familiar with key health messages, have intimate knowledge of the local dialect and context, and were already reporting health data at the community level.

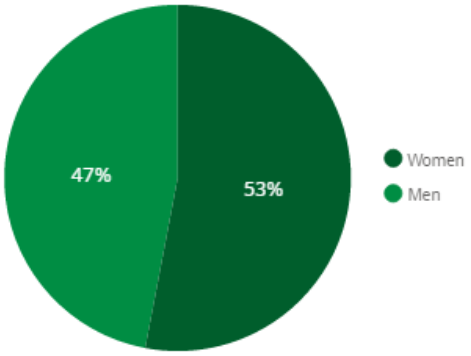
5. Conducted monitoring support to the listening groups. After the training, the facilitators conducted weekly listening group sessions in their community, most often in their homes. Attendance ranged from 15 to 20 people per session. Each session lasted on average one hour. Topics discussed were based on the radio story aired on that day. Radio stations were directed to broadcast stories based on seasonal illnesses such as diarrhea from October to March, malaria from May to June and pneumonia from April to June. The MAHEFA field team attended RLG sessions on a quarterly basis to monitor, provide feedback, and encourage facilitators who also submitted monthly reports to MAHEFA on their RLG Activities.

Results

MAHEFA developed a total of 70 short format radio spots (3-5 minutes each), 21 long format broad casts (11 theatrical skits and 10 drama tales) to broadcast weekly on local radios and address health themes including maternal, newborn and child health, family planning, gender issues, and water, sanitation and hygiene.

MAHEFA partnered with 26 local radio stations to air the broadcasts at least nine times per day, 20 days each month. Theatrical skits on maternal and neonatal health and stories on child health aired twice a week for a total of eight broadcasts per month. These broadcasts were popular and some stations continued them after the end of the contract with MAHEFA due to audience demand. Over the life of the MAHEFA program, there were at least 7,932 radio broadcasts that worked to influence health norms of RLG participants in targeted program regions (Table 1). Figure 2 summarizes the achievements of MAHEFA's Radio Listening Program.

Figure 2. Participants in Radio Listening Group Activities FY2015, by gender (n=219,210)



In FY2015, there were a total of 219,210 community members who participated in the RLG sessions in their village. These participants listened to key health messages and discussed their actions on those actions.

Table 1. Topics of Radio Broadcasts and its Frequency for RLG in MAHEFA Regions, by Technical Themes (2011-2016)

Technical themes of RLG Broadcasts	No. of Broadcasts
Maternal, Newborn and Child Health	
WASH	2059
Nutrition and vaccination	1541
LLITN use	921
ANC and delivery at CSB	810
c-IMCI	472
Vitamin A & deworming	225
Danger signs (CU5 and women)	54
Newborn cord infection & post-partum hemorrhage	28
Family Planning	
Invitation card for family planning	842
Early marriage	325
RH & STI	213
Health promotion	
Gender	237
Behavior change communication/care group households	123
Healthy Living	27
Social responsibility	23
Decision-making	20
Health advocacy	12
Total broadcasts	**7932**

Challenges

Coordination and engagement with other implementing partners. Some of MAHEFA's implementing partners who were responsible for the implementation of the RLG activities did not provide adequate support to the RLGs in the implementing regions. As a result, the RLGs did not happen regularly causing irregularities in availability of RLG sessions and reporting. Also, some community leaders did not understand the activity and therefore did not mobilize their community to support facilitators when they faced challenges.

Radio signal coverage. The RLG depends entirely on the radio signal coverage. Facilitators in some areas reported that their sessions could not be conducted due to unreliable and/or low signal on the day of the activity.

Radio quality. Low quality of the donated radios required frequent repairs and some were broken early in the program. During the five year period, MAHEFA needed to replace nearly 80 percent of the distributed radios.

Turnover of RLG facilitators. During the life of the program, there were 866 trained RLG facilitators. Of that total, 103 facilitators left their role after some period of time. When this happened, the community recruited new facilitators and provided additional

trainings. Former facilitators explained that they found it difficult to balance earning their livelihoods with working as a volunteer to facilitate the RLG sessions.

Lessons Learned and Recommendations

Conduct workshops with RLG implementing partners to ensure clear understanding on the approach. Conducting a regional-level workshop on the design and the required actions to establish a RLG among stakeholders at program onset is critical to ensure that all partners develop a common understanding and commitment to the activity. The workshop should also be used to discuss key messages, types of radio products and work tools for the facilitators and community leaders that are appropriate for local interest and context.

Orient community leaders on the RLG approach. A comprehensive orientation workshop for community leaders should be organized at inception that highlights the important role that RLGs can play to change health behaviors. The workshop should emphasize the role of community leaders in mobilizing the community to participate in the activity and monitoring to ensure the functionality of the RLGs.

Disseminate radios with two low-cost sources of energy. MAHEFA's use of radios with both solar and crank energy sources increased the likelihood of tuning into local stations. Depending on the local context, the appropriate radio type should be provided.

Strengthen the link between CHV health activities and RLGs. CHVs would be effective listening group facilitators since they were appointed to the CHV position, know the population, are experienced in leading health discussions, have earned the trust of community members, and are experienced in data reporting. CHVs who are facilitators of RLGs can host RLGs in the *Toby* and ensure widespread dissemination of messages.

FOR MORE INFORMATION, PLEASE CONTACT:

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